

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/22/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175295	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/18/2016
NAME OF PROVIDER OR SUPPLIER SMITH CENTER OPERATOR, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 117 W 1ST STREET #369 SMITH CENTER, KS 66967		
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F 000	INITIAL COMMENTS	F 000			
F 250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: The facility had a census of 34 residents. The sample included 8 residents. Based on observation, record review and interview the facility failed to provide medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for 1 of 1 residents reviewed for social services. (#18)</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Resident #18's diagnosis from the 4/1/16 signed Physician Order Sheet included Bipolar Disorder (major mental illness that caused people to have episodes of severe high and low moods). <p>The quarterly (MDS) Minimum Data Set assessment, dated 3/23/16, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 15, which indicated the resident had intact cognition. The MDS indicated the resident required supervision and set up help for bed</p>	F 250			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 250	<p>Continued From page 1</p> <p>mobility, transfers, and used a walker for ambulation. The MDS indicated the resident had behaviors and his/her mood stable.</p> <p>The 11/16/15 behavioral (CAA) Care Area Assessment summary indicated the resident has manic behaviors (mood characterized by an unstable expansive emotional state, extreme excitement, hyperactivities) at times. The resident talks about irrelevant things or switches the subject.</p> <p>The 3/23/16 care plan directs the staff to identify themselves when entering the resident's room. Reduce any distractions when speaking with the resident by making eye contact with the resident. The care plan directed the staff to return later if the resident is agitated.</p> <p>The 3/30/16 at 11:46 PM, nurse's notes stated the resident in a manic phase of his/her bipolar disease, (major mental illness that causes people to have episodes of severe high and low moods) room floor cluttered with items, and resident refusing to have staff pick up the items scattered on the floor.</p> <p>The 3/31/16 at 4:36 AM, nurse's notes stated the resident has been awake from 12:15 AM to 2:00 AM sitting in his/her recliner chair. The resident walked out to the desk with his/her walker and then back to his/her room.</p> <p>The 4/4/16 at 3:30 AM, nurse's notes stated the resident in a manic behavior phase. The nurse's notes further stated the resident had not slept from 10:00 PM to 3:00 AM. The resident worked on a sewing project, hand washed 2 skirts and a</p>	F 250			

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F 250	<p>Continued From page 2</p> <p>blouse in his/ her sink, and then asked the staff to hang them to dry.</p> <p>The 4/5/16 at 6:40 PM, nurse's notes stated the resident had been compulsive with talking constantly and loudly at meal time.</p> <p>The 4/7/16 at 8:00 PM, nurse's notes stated the resident continues in a manic phase, and has numerous items cluttering the floor in his/her room. The note stated the resident attempts to use his/her walker to walk around the items on the floor.</p> <p>The 4/8/16 psychiatric nurse consultant G progress notes stated the staff report issues with the manic resident, working on one project and then another before completing the first project. Resident's room literally filled with items every where and all over the floor with nothing being put away. The resident talking excessively, jumping from one subject to another. The resident currently receives Effexor (antidepressant medication) XR (extended release) 75(MG) milligrams (PO) by mouth daily, Aricept (anti Alzheimer's medication) 10 mg, 2 tablets daily and Depakote (seizure medication also used for Bipolar Disorder) 500 mg PO BID (twice a day). No new orders at this time.</p> <p>The 4/11/16 at 4:30 AM, nurse's notes stated the resident has "totally trashed" his/her room. The resident has dug out papers, along with clothing items, and scattered the items all over the room floor.</p> <p>On 4/11/16 at 10:10 AM, observation of the resident's room revealed M&M candy scattered all over the floor. Further observation revealed a</p>	F 250			

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F 250	<p>Continued From page 3</p> <p>3(ft) foot by 3ft area in center of the room floor with paper clips, and a large amount of puzzle pieces, and a large amount of clothing scattered across the resident's bed.</p> <p>On 4/12/16 at 3:15 PM, observation revealed the resident, seated on a chair, in his/her room. Continued observation revealed a large stuffed purple unicorn on the floor in the center of the room. Continued observation revealed 2 large wicker baskets with magazines, numerous crumbled up paper, M&M's, tootsie rolls and numerous paper clips scattered across the room floor.</p> <p>On 4/14/16 at 10:30 AM, observation revealed the resident ambulating down the hallway to the business office. Further observation revealed the resident then ambulated into the social service office. Further observation revealed the social service office with no staff in the room, no lights on, and the resident looking through the closet and then desk drawers.</p> <p>On 4/14/16 at 8:15 AM, Nurse B verified the resident scatters items all over his/her floor. Nurse B also verified the resident's manic behaviors have escalated in the past couple of weeks. Nurse B also verified psychiatric nurse consultant G had been notified of the increase in the manic behaviors on 4/8/16 with no new orders.</p> <p>On 4/14/16 at 9:00 AM, Administrative Nurse A verified the resident's behaviors have escalated and verified more should be done for the resident due to the increase in his/her behaviors.</p> <p>On 4/14/16 at 10:50 AM, Social Service Staff C</p>	F 250			

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F 250	Continued From page 4 verified the resident has had increased behaviors. Social Service Staff C verified no social service assessment was completed for the resident regarding the resident's increased behaviors. Upon request the facility failed to provide a policy regarding social services. The facility failed to provide Social Services to meet the individual needs of Resident #18 who had been displaying manic bipolar behaviors.	F 250			
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: The facility had a census of 34 residents. The sample included 8 residents. Based on observation, and interview, the facility failed to provide maintenance and housekeeping services necessary to maintain a sanitary and orderly environment on the interior of the facility on 3 of 3 halls. Findings included: - On 4/13/16 at 8:30 AM, on environmental tour, observation revealed the following: South hall: Resident #35's outside bathroom door knob bent	F 253			

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F 253	<p>Continued From page 5</p> <p>downward and was not attached securely to the door.</p> <p>Resident #20's window blind bent in several places.</p> <p>Resident #22's room had 3 or 4 of the window curtain hooks missing causing the curtain to gap at the top.</p> <p>Resident #31's left hand rail around the toilet in the bathroom was bent with no cap on the bottom of the hand rail.</p> <p>Resident #27's baseboard in the bathroom was loose from the wall for approximately 3 feet and leaning towards the toilet.</p> <p>West hall:</p> <p>Resident #24's window curtain rod was bent downward towards the west side of the rod and the curtain did not hang straight.</p> <p>North hall:</p> <p>Resident #10's and #16's privacy curtain between the 2 residents' beds was torn approximately 12-14 inches near the top of the curtain and 6 hooks were missing at the south end of the privacy curtain which allowed the curtain to be attached to the ceiling track causing the curtain to touch the floor. The window curtain rod was bent in the middle of the rod so the curtain did not hang straight.</p> <p>On 4/14/16 at 8:20 AM, Maintenance Staff D verified the above observations during the environmental tour. Maintenance Staff D stated a maintenance request book is kept at the nurse's station to inform him/her of any maintenance work needing to be completed and he/she stated</p>	F 253			

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F 253	Continued From page 6 the staff also verbally inform him/her of any issues needing repair. On 4/14/16 at 9:00 AM, Housekeeping Staff E stated he/she informs the maintenance man of any concerns in the residents' rooms when daily cleaning of the rooms such as window curtains not being attached to the curtain rod, torn privacy curtains or other maintenance issues. Housekeeping Staff E stated he/she also writes any maintenance concerns in the maintenance request book at the nurse's station. On 4/14/16 at 9:23 AM, Nurse F stated he/she reports any maintenance issues to the maintenance man verbally, or writes the concerns in the maintenance request book at the nurse's station. Upon request the facility had no policy for the maintenance department to monitor for the upkeep of the residents' privacy or window curtains. The facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior, in good repair, for the 34 residents who reside in the facility.	F 253			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309			

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F 309	Continued From page 7 This REQUIREMENT is not met as evidenced by: The facility had a census of 34 residents. The sample included 8 residents. Based on observation, record review and interview, the facility failed to provide the necessary care and services, including individualized care related to manic behavior (mood characterized by an unstable expansive emotional state, extreme excitement, hyperactivities) for 1 of 8 sampled residents. (#18) Findings included: - Resident #18's diagnosis from the 4/1/16 signed Physician Order Sheet included Bipolar Disorder (major mental illness that causes people to have episodes of severe high and low moods). The quarterly (MDS) Minimum Data Set assessment, dated 3/23/16, indicated the resident has a (BIMS) Brief Interview for Mental Status score of 15, which indicated the resident had intact cognition. The MDS indicated the resident required supervision and set up help for bed mobility, transfers and used a walker for ambulation. The MDS indicated the resident had behaviors and his/her mood stable. The 11/16/15 behavioral (CAA) Care Area Assessment summary indicated the resident has manic behaviors at times. The resident talks about irrelevant things or switches the subject. The 3/23/16 care plan directs the staff to identify	F 309			

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F 309	<p>Continued From page 8</p> <p>themselves when entering the resident's room. Reduce any distractions when speaking with the resident, by making eye contact with the resident. The care plan directed the staff to return later if the resident is agitated.</p> <p>The 3/30/16 at 11:46 PM, nurse's notes stated the resident in a manic phase of his/her bipolar disease, (major mental illness that causes people to have episodes of severe high and low moods) room floor cluttered with items, and resident refusing to have staff pick up the items scattered on the floor.</p> <p>The 3/31/16 at 4:36 AM, nurse's notes stated the resident had been awake from 12:15 AM to 2:00 AM sitting in his/her recliner chair. The resident had walked out to the desk with his/her walker and then back to his/her room.</p> <p>The 4/4/16 at 3:30 AM, nurse's notes stated the resident in a manic behavior phase. The nurse's notes further stated the resident had not slept from 10:00 PM to 3:00 AM. The resident worked on a sewing project, hand washed 2 skirts and a blouse in his/ her sink and then asked the staff to hang them to dry.</p> <p>The 4/5/16 at 6:40 PM, nurse's notes stated the resident had been compulsive with talking constantly and loudly at meal time.</p> <p>The 4/7/16 at 8:00 PM, nurse's notes stated the resident continues in a manic phase, and has numerous items cluttering the floor in his/her room. The note stated the resident attempts to use his/her walker to walk around the items on the floor.</p>	F 309			

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F 309	<p>Continued From page 9</p> <p>The 4/8/16 psychiatric nurse consultant G progress notes stated the staff report issues with the manic resident working on one project and then another before completing the first project. Resident's room literally filled with items every where and all over the floor with nothing being put away. The resident talking excessively jumping from one subject to another. The resident currently receives Effexor (antidepressant medication) XR (extended release) 75(MG) milligrams (PO) by mouth daily, Aricept (anti Alzheimer's medication) 10 mg, 2 tablets daily and Depakote (seizure medication also used for Bipolar Disorder) 500 mg PO BID (twice a day). No new orders at this time.</p> <p>The 4/11/16 at 4:30 AM, nurse's notes stated the resident has "totally trashed" his/her room. The resident has dug out papers, along with clothing items, and scattered the items all over the room floor.</p> <p>On 4/11/16 at 10:10 AM, observation of the resident's room revealed M&M candy scattered all over the floor. Further observation revealed a 3(ft) foot by 3ft area in center of the room floor with paper clips, and a large amount of puzzle pieces, and a large amount of clothing scattered across the resident's bed.</p> <p>On 4/12/16 at 3:15 PM, observation revealed the resident, seated on a chair, in his/her room. Continued observation revealed a large stuffed purple unicorn on the floor in the center of the room. Continued observation revealed 2 large wicker baskets with magazines, numerous crumbled up paper, M&M's, tootsie rolls and numerous paper clips scattered across the room</p>	F 309			

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F 309	Continued From page 10 floor. On 4/14/16 at 10:30 AM, observation revealed the resident ambulating down the hallway to the business office. Further observation revealed the resident then ambulated into the social service office. Further observation revealed the social service office with no staff in the room, no lights on, and the resident looking through the closet and then desk drawers. On 4/14/16 at 8:15 AM, Nurse B verified the resident scatters items all over his/her floor. Nurse B also verified the resident's manic behaviors have escalated in the past couple of weeks. Nurse B also verified psychiatric nurse consultant G had been notified of the increase in the manic behaviors on 4/8/16 with no new orders. On 4/14/16 at 9:00 AM, Administrative Nurse A verified the resident's behaviors have escalated and verified more should be done for the resident due to the increase in his/her behaviors. Upon request the facility failed to provide a policy regarding necessary individualized care and services for mental illness. The facility failed to provide care and services to meet the individual needs of Resident #18 who had been displaying manic bipolar behaviors.	F 309			
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to	F 312			

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F 312	<p>Continued From page 11</p> <p>maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: The facility had a census of 34 residents. The sample included 8 residents, of which 2 residents were reviewed for (ADLs) Activity of Daily Living. Based on observation, record review and interview, the facility failed to provide the necessary care and services to maintain appropriate personal hygiene for 1 of 2 residents. (#24)</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Resident #24's quarterly (MDS) Minimum Data Set assessment, dated 3/17/16, indicated the resident had short and long term memory loss and severely impaired daily decision making. The MDS indicated the resident displayed fluctuating inattention, continuous altered level of consciousness, and psychomotor retardation (greatly reduced or slowed level of activity or mental processing). The MDS indicated the resident totally dependent on 2 staff for bed mobility, transfers, toileting, bathing, and totally dependent on 1 staff for locomotion on/off unit, dressing and personal hygiene. <p>The 1/4/16 (CAAs) Care Area Assessment for ADLs, indicated the resident required total staff assistance with ADLs due to decline in functioning, advanced age, and no longer able to ambulate or transfer without a mechanical lift.</p> <p>The 3/23/16 care plan directed the staff to provide</p>	F 312			

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F 312	<p>Continued From page 12</p> <p>extensive to total assistance with bed mobility, toileting, transfers and personal hygiene.</p> <p>The 4/28/15 physician's orders instructed the staff to instill Systane balance solution (artificial tears), 1 drop, each eye, twice a day.</p> <p>The 12/14/15 Hospice notes described the resident's general appearance as unkempt (untidy in appearance).</p> <p>The 12/17/15 Hospice notes described the resident's general appearance as unwashed.</p> <p>On 4/11/16 at 2:05 PM, during initial tour, observation revealed the resident had a dried crusty yellow substance in both corners of his/her right eye.</p> <p>On 4/12/16 at 8:30 AM, observation revealed the resident continued to have a dried crusty yellow substance in both corners of his/her right eye and also on his/her top and bottom eye lashes of his/her right eye.</p> <p>On 4/14/16 at 8:50 AM, observation revealed the resident with a scant amount of a thick yellow substance on his/her right lower eyelashes.</p> <p>On 4/13/16 at 3:25 PM, Nurse Aide H stated he/she washes a resident's face whenever it needs it but especially if he/she notes the resident has yellowish substance in the corners of their eyes.</p> <p>On 4/14/16 at 8:04 AM, Nurse Aide I stated he/she washed the resident's face and cleaned his/her eyes in the morning, after breakfast and as needed.</p>	F 312			

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F 312	Continued From page 13 On 4/13/16 at 3:20 PM, Nurse B stated the aides were to wash the residents' face when getting them up, after meals and as needed. Nurse B stated the resident receives eye drops, twice a day, and his/her eyes do matter a lot. On 4/14/16 at 11:05 AM, Administrative Nurse A stated he/she expected the aides to wash the residents' face and clean his/her eyes every morning, after meals and as needed. Upon request the facility did not have a policy for washing resident's face or providing routine eye care. The facility failed to provide personal hygiene care for totally dependent Resident #24.	F 312			
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility had a census of 34 residents. The sample included 8 residents. Based on observation, record review and interview the facility failed to provide an environment free of accident hazards for 1 of 3 residents reviewed for accidents and for 5 cognitively impaired	F 323			

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F 323	<p>Continued From page 14 independently mobile residents.(#18)</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Resident #18's 3/1/16, physician order sheet indicated a diagnosis of Bipolar Disorder (major mental illness that caused people to have episodes of severe high and low moods). <p>The quarterly (MDS) Minimum Data Set assessment, dated 3/23/16, indicated the resident has (BIMS) Brief Interview for Mental Status score of 15, which indicated the resident had intact cognition. The MDS indicated the resident required supervision and set up help for bed mobility, balance not steady, no recent falls, functional limitation of one side upper extremity and used a walker for ambulation.</p> <p>The 11/16/15 fall (CAA) Care Area Assessment summary indicated the resident had poor balance and poor safety awareness.</p> <p>The 3/26/16 care plan informed the staff to encourage the resident to keep his/her room floor picked up to avoid trip concerns because the resident often has the floor cluttered in his/her room. Staff are to pick up items off the floor when floor is cluttered.</p> <p>The 3/8/16 Psychiatric Nurse Consultant G notes, stated the resident non compliant with picking up his/her room, safety is key to him/her at this time, due to keeping the floor cluttered. Staff are educated on the importance of keeping the floor in the resident's room picked up.</p> <p>The 3/30/16 at 11:46 PM, nurse's notes stated the</p>	F 323			

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F 323	<p>Continued From page 15</p> <p>resident in a manic phase of his/her bipolar disease, (major mental illness that causes people to have episodes of severe high and low moods) the floor in his/her room cluttered with items, and he/she refuses to allow staff to pick up the items scattered on the floor.</p> <p>The 3/31/16 fall risk assessment revealed the resident at high risk for falls.</p> <p>The 4/7/16 at 8:00 PM, nurse's notes stated the resident continues in a manic phase, and has numerous items cluttering the floor in his/her room. The resident attempts to use his/her walker to walk around the items on the floor.</p> <p>The 4/11/16 at 4:30 AM, nurses notes stated the resident has "totally trashed" his/her room. The resident has dug out papers along with clothing items and scattered the items all over the room floor.</p> <p>The 4/12/16 at 10:45 AM, social service note stated liquid house cleaning items were found in the resident's room. Staff informed the resident the items were not allowed in his/her room and staff locked the items in the social service office.</p> <p>On 4/11/16 at 10:10 AM, observation of the resident's room revealed M&M's candy scattered all over the floor. Further observation revealed a 3(ft) foot by 3ft area in the center of the room floor with paper clips, and a large amount of puzzle pieces, and a large amount of clothing scattered across the resident's bed.</p> <p>On 4/12/16 at 3:15 PM, observation revealed the resident, seated on a chair, in his/her room. Continued observation revealed a large stuffed</p>	F 323			

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F 323	<p>Continued From page 16</p> <p>purple unicorn on the floor in the center of the room. Continued observation revealed 2 large wicker baskets with magazines, numerous crumbled up paper, M&M's, tootsie rolls, and numerous paper clips scattered across the room floor.</p> <p>On 4/14/16 at 10:30 AM, observation revealed the resident ambulating down the hallway to the business office. Further observation revealed the resident then ambulated into the social service office. Further observation revealed the social service office with no lights on and the resident looking through the closet and then desk drawers.</p> <p>On 4/14/16 at 8:15 AM, Nurse B verified the resident scatters items all over his/her floor. Nurse B also verified the resident uses a walker for ambulation and is at risk for falls. Nurse B also verified the staff are to keep the resident's floor free of clutter to prevent falls.</p> <p>On 4/14/16 at 9:00 AM, Administrative Nurse A verified the resident's room had large amounts of items scattered across his/her room floor, and the staff are to keep the floor free of clutter to prevent resident falls.</p> <p>The 4/2010 facility policy for fall prevention states each resident's care plan will be individualized to meet safety needs for each resident.</p> <p>The facility failed to ensure Resident #18's environment free of accident hazards and to provide adequate supervision.</p> <p>- On 4/13/16 at 8:30 AM, during initial tour,</p>	F 323			

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F 323	Continued From page 17 observation revealed a 1 liter spray bottle of disinfectant cleaner, with the warning label, to keep our of reach of children, in a cabinet, under the nurse's station counter. The warning label also indicated, it caused substantial but temporary eye injury, harmful if absorbed through the skin, and do not drink. On 4/11/16 at 8:45 AM, Nurse B stated he/she didn't know the disinfectant cleaner was under the nurse's station counter and removed the cleaner from the cabinet. On 4/11/16 at 11:10 AM, Administrative Nurse A verified there were 5 independently mobile, cognitively impaired residents in the facility. The 12/2009 facility's storage areas, maintenance policy stated cleaning supplies must be stored as instructed on the labels of such products. The facility failed to provide a safe environment for the 5 cognitively impaired, independently mobile residents, who reside in the facility.	F 323			
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a	F 329			

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F 329	<p>Continued From page 18</p> <p>resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: The facility had a census of 34 residents. The sample included 8 residents with 5 residents reviewed for unnecessary medications. Based on observation, record review and interview the facility failed to ensure 1 of the 3 residents reviewed for antipsychotic medications remained free from unnecessary medications by failure to adequately monitor for potential side effects. (#38)</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Resident #38's diagnosis from the 4/1/16 signed Physician Order Sheet included dementia with behavioral disturbances, (a loss of brain function that occurs with certain diseases which affects memory, thinking, language, judgment and behavior). <p>The quarterly (MDS) Minimum Data Set assessment, dated 4/8/16, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 7 which indicated the resident had</p>	F 329			

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F 329	<p>Continued From page 19</p> <p>severely impaired cognition. The MDS indicated the resident had verbal and physical behaviors toward others and received antipsychotic medication for 7 days of the look back period.</p> <p>The 1/12/16 psychotropic (CAA) Care Area Assessment summary indicated the Psychiatric Nurse Consultant assessed the resident monthly for the use of the antipsychotic medication.</p> <p>The 1/26/16 care plan informed the staff the resident has behavior problems related to his/her dementia. The care plan further instructed the staff to monitor and document side effects and effectiveness of the medication.</p> <p>The 1/6/16 physician's order instructed the staff to administer Seroquel (an antipsychotic medication), 25 (mg) milligrams, at (hs) bedtime.</p> <p>Review of the Registered Pharmacy Consultant report, dated 3/4/16, instructed the staff to complete an (AIMS) Abnormal Involuntary Movement Scale assessment (used to detect (TD) Tardive Dyskinesia (an abnormal condition characterized by involuntary repetitive movement of the muscles of the face, limbs, and trunk). Further review of the medical record revealed the staff had not completed an AIMS assessment as recommended by the pharmacist.</p> <p>On 4/12/16 at 1:30 PM, observation revealed the resident, seated on a recliner chair, in his/her room, reading a newspaper.</p> <p>On 4/13/16 at 9:15 AM, Administrative Nurse A verified the staff had not completed an AIMS assessment.</p>	F 329			

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F 329	Continued From page 20 The 2/2014 facility policy for use of antipsychotic medications stated the qualified staff would conduct an AIMS assessment quarterly, annually and any significant change in a residents condition. The facility failed to ensure Resident #38's drug regimen was free from unnecessary medications by adequately monitoring and assess for sude effects of an antipsychotropic medication.	F 329			
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: The facility had a census of 34 residents. The sample included 8 residents. Based on observation, record review and interview the facility failed to store, prepare, distribute, and serve food under sanitary conditions on 2 of the 2 onsite days, for the 34 residents residing in the facility, who received meals from the facility's kitchen. Findings included:	F 371			

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F 371	<p>Continued From page 21</p> <p>- On 4/11/16 at 8:30 AM, during initial tour, observation revealed the single and double doored silver refrigerators and freezer doors had numerous greasy finger prints on the outside of each door.</p> <p>On 4/13/16 at 11:10 AM, observation revealed the following:</p> <ol style="list-style-type: none"> 1) the refrigerators and freezer doors continued to have greasy finger prints on the outside of each door. 2) inside the single door silver refrigerator, observation revealed a 46 ounce container of prune juice with a manufacturing label stating, use by 1/13/15, and hand written on the container, opened on 3/4, with no year. 3) the lids on the bulk flour and sugar containers greasy to touch. 4) #10 scoop serving, with a green handle, observed in the clean silverware drawer with dried food particles inside the scoop. 5) the sliding doors for the cabinets under the counter, by the kitchen serving window, had food crumbs in the tracks and when the doors were opened it sounded like potato chips being crunched. <p>On 4/13/16 at 11:10 AM, Dietary Staff J verified the above findings. Dietary Staff J stated the weekly cleaning schedule included cleaning of the outside of the refrigerator, freezers, and the tracks of the cabinets, but verified no documentation to support the dietary staff completed the cleaning as scheduled.</p>	F 371			

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F 371	Continued From page 22 Review of the 3/20/16-4/11/16 dietary weekly cleaning schedule revealed numerous missing documentation. Upon request the facility did not provide a kitchen cleaning schedule policy. The facility failed to store, prepare, distribute and serve food under sanitary conditions for the 34 residents residing in the facility, who receive meals from the facility's kitchen.	F 371			
F 456 SS=F	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: The facility had a census of 34 residents. The sample included 8 residents. Based on observation, and interview the facility failed to maintain essential kitchen equipment in a safe operating condition in 1 of 1 facility kitchens. Findings included: - On 4/13/16 at 11:10 AM, during kitchen tour, observation revealed Dietary Staff J preparing hamburgers for the resident's noon meal in 2 skillets on the left and right front burners on the gas stove. Dietary Staff J stated the gas range pilot lights go out frequently and the dietary staff have to re-light the burners with a lighter. Dietary Staff J stated the dietary staff had to check to	F 456			

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F 456	<p>Continued From page 23</p> <p>ensure the pilots were lit prior to leaving the kitchen. Dietary Staff J stated the middle back and the right back burners would not automatically light even when the pilots were lit and staff had to use a lighter to light them. Dietary Staff J stated he/she did not use the middle and right back burners often and the burners had been like this since he/she started working at the facility 3 years ago.</p> <p>On 4/13/16 at 1:10 PM, Dietary Staff K stated he/she was unaware of the issues with the pilots going out on the stove burners and the 2 back pilot lights needing to be lit with a lighter.</p> <p>On 4/13/16 at 1:25 PM, Administrative Staff L stated he/she was unaware of the issues with the pilot lights but would have a repairman check the gas stove.</p> <p>On 4/13/16 at 2:30 PM, Dietary Staff M, stated the pilot lights would go out maybe 1 time a month and he/she re-lights the pilot lights with a lighter. Dietary Staff M stated he/she had worked in the kitchen for 5 years and thought the gas stove pilots would go out occasionally. Dietary Staff M further stated he/she had not noticed any gas fumes at any time in the kitchen but when he/she would turn on a burner and the pilot was not lit he/she would then smell gas, and then he/she would turn the burner off, turn on the range vent and then light the burner with the lighter.</p> <p>On 4/13/16 at 3:15 PM, Administrative Staff L stated he/she had been to the kitchen and checked out the pilot light. Administrative Staff L stated all pilot lights on the stove were lit but the back left one. Administrative Staff L indicated</p>	F 456			

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F 456	<p>Continued From page 24</p> <p>he/she discovered each of the other pilot lights had 3 small openings from the pilot to the burner except for the back left one, and noted the 3 small openings were covered with grease. Administrative Staff L stated after cleaning the grease away from the 3 small openings, the pilot did light after 5-10 seconds.</p> <p>On 4/14/16 at 8:30 AM, during the environmental tour, Maintenance Staff D stated he/she was unaware of any issues with the pilot lights not lighting on the gas stove in the facility's kitchen or having to light the pilot light with a lighter.</p> <p>Upon request, the facility did not provide a policy for maintaining the gas stove in the kitchen.</p> <p>The facility failed to maintain the kitchen gas stove in a safe operating condition for the 34 residents residing in the facility.</p>	F 456		